New Patient Medical History Form

Desoto Family Care Clinic
346 Stateline Road W
8888 Midsouth Drive Suite 110
(662) 510-5353 | (662) 782-0300
fax: 662-404-8861

List of names & dates of surgeries:

____
____
____

Medications:

____
____
____

Allergies:

____
____
____

Family History

Has anyone in your family had any of the following conditions?Check if yes and indicate relationship to you.

- ☐ Cancer/Polyps____________________ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma, Other____________________________
- ☐ Anemia
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Anesthesia Reaction
- ☐ Bleeding Problems
- ☐ Hepatitis
- ☐ Other____________

Emergency Contact

Last Name:________________________ **First Name:**________________________

Phone Number:____________________ **Relation:**________________________

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Social History

Alcohol use-	☐ Never	☐ Occasionally	☐ Daily	Type:________________ ____________________
Tobacco use-	☐ Never	☐ Previously, but quit	☐ Daily	Packs per Day________ for__________years.
Drugs use-	☐ Never	☐ Occasionally	☐ Daily	Type:________________ ____________________

What is your occupation?: ____

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual
☐ Other:________________________ ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Separated

Name of spouse of significant other: ____________________________________

Children:
Number of children________
Number of grandchildren________

Women:
Number of pregnancies________
Number of deliveries________
-Vaginal________ -C-Sections________
-Miscarriages________, VIPs (abortions)

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Name:______________________________ DOB:__________________

Reason for Visit:______________________________ Today's Date:__________

Personal Medical History

Have you ever had any of the following conditions?Check box if yes.

- ◯ Anemia
- ◯ Arthritis
- ◯ Asthma
- ◯ Cancer
- ◯ COPD
- ◯ Clotting Disorder
- ◯ Congestive Heart Failure
- ◯ Crohn's Disease
- ◯ Depression
- ◯ Diabetes
- ◯ Diverticulitis
- ◯ Emphysema
- ◯ Endocrine Problems
- ◯ GERD
- ◯ Glaucoma
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ IBS
- ◯ Kidney Disease
- ◯ Kidney Stones
- ◯ Myocardial Infarction
- ◯ Peptic Ulcer Disease
- ◯ Seizures
- ◯ Stroke
- ◯ Ulcerative Colitis

Personal Surgical History

Have you ever had any of the following surgeries?Check box if yes.

- ◯ Adrenal Gland Surgery
- ◯ Appendectomy
- ◯ Bariatric Surgery
- ◯ Bladder Surgery
- ◯ Breast Surgery
- ◯ Carotid Endarterectomy
- ◯ Cataract Surgery
- ◯ Cesarean Section
- ◯ Cholecystectomy
- ◯ Colon Surgery
- ◯ Coronary Artery Bypass Graft
- ◯ D&C
- ◯ Esophagus Surgery
- ◯ Gastric Bypass Surgery
- ◯ Hemorrhoid Surgery
- ◯ Hernia Repair
- ◯ Hysterectomy
- ◯ Kidney Surgery
- ◯ Knee Arthroplasty
- ◯ Neck Surgery
- ◯ Prostate Surgery
- ◯ Small Intestine Surgery
- ◯ Spine Surgery
- ◯ Stomach Surgery
- ◯ Thyroid Surgery
- ◯ Tonsillectomy